BULK RATE
U.S. POSTAGE
PAID
SPRINGFIELD, MA
PERMIT NO. 695

THE HAMPDEN HIPPOCRAT
1414 STATE STREET
SPRINGFIELD, MA 01109

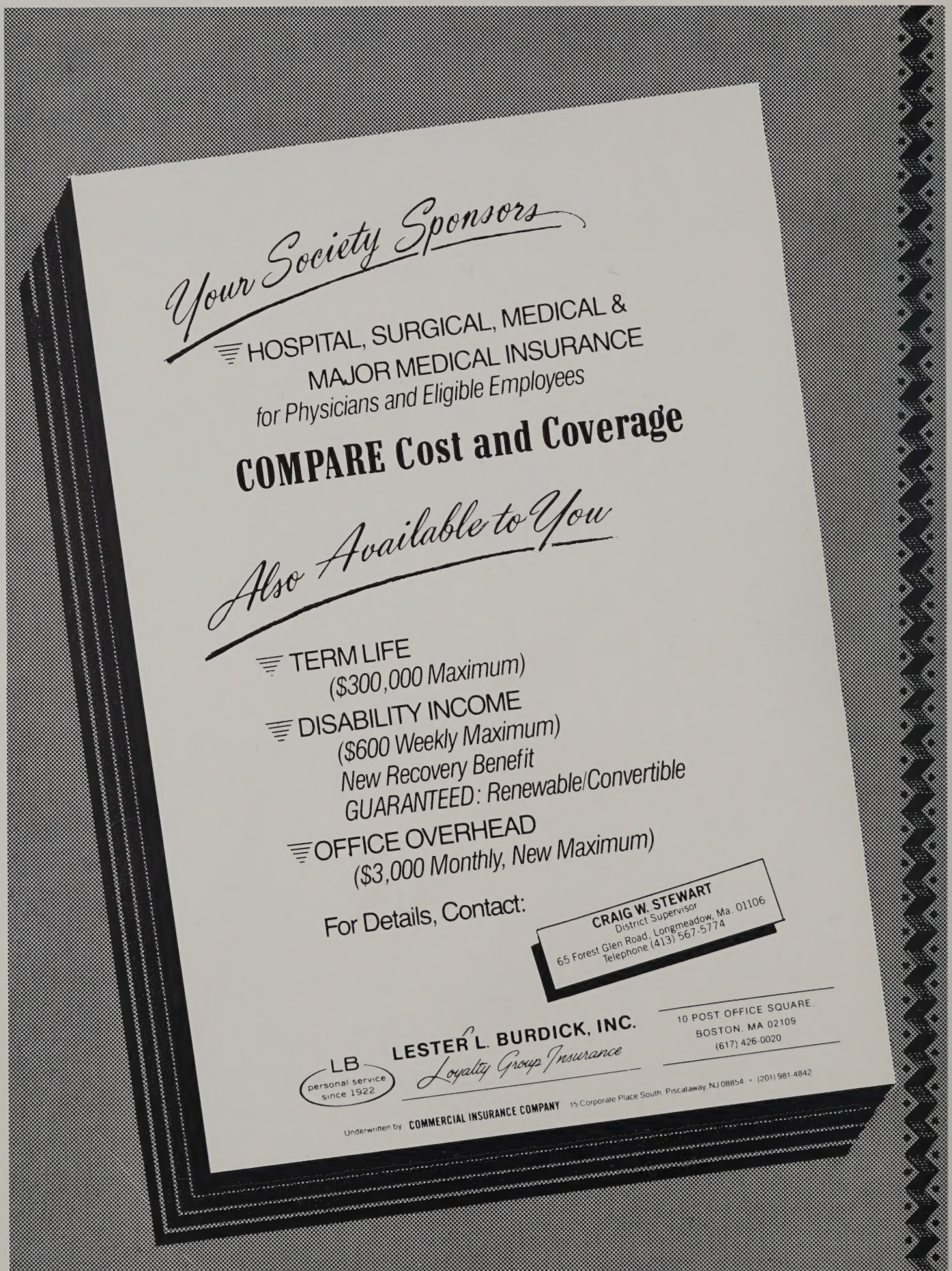
ADDRESS CORRECTION REQUESTED

The Hampden Hippocrat

June-July
1985

Barbara P. Rockett, M.D.

President 1985-1986
Massachusetts Medical Society


Your Society Sponsors
HOSPITAL, SURGICAL, MEDICAL &
MAJOR MEDICAL INSURANCE
for Physicians and Eligible Employees
COMPARE Cost and Coverage
Also Available to You
TERM LIFE
($300,000 Maximum)
DISABILITY INCOME
($600 Weekly Maximum)
New Recovery Benefit
GUARANTEED: Renewable/Convertible
OFFICE OVERHEAD
($3,000 Monthly, New Maximum)
For Details, Contact:
CRAIG W. STEWART
District Supervisor
65 Forest Glen Road, Longmeadow, Ma. 01106
Telephone (413) 567-5774
LB
personal service
since 1922
LESTER L. BURDICK, INC.
Loyalty Group Insurance
10 POST OFFICE SQUARE
BOSTON, MA 02109
(617) 426-0020
Underwritten by COMMERCIAL INSURANCE COMPANY 15 Corporate Place South, Piscataway, NJ 08854 • (201) 981-4842

Carol L. Nystrom
Executive Secretary

Carol A. Sarno
Office Secretary

OFFICERS

Augusto G. Asinas, *President*
Gregory A. Slachta, *Vice President-President Elect*
William W. Walthall, Jr., *Secretary*
John R.S. Remsberg, *Treasurer*
Victoria Levander, *Assistant Secretary*

EXECUTIVE COMMITTEE

Lorne C. Smith	Ex-officio	Terry D. Ryan
William W. Walthall, Jr	Ex-officio	Gregory A. Slachta
John R.S. Remsberg	Ex-officio	Victoria Levander
Alan R. Munro	1986	Terrence M. O'Neill
Alfred Hutt	1987	Bruce B. Stoler
Alicia M. Ross	1988	Nicholas P.W. Coe

CHAIRPERSON OF COMMITTEES

Kenneth M. Frankel	*Mediation*
William J. Baker	*Publications*
Nicholas P.W. Coe	*Publications*
Terry D. Ryan	*Publications*
Terry D. Ryan	*Public Relations*
Terrence M. O'Neill	*Legislative*
William W. Walthall, Jr.	*Auxiliary*
Lorne C. Smith	*Insurance*
Lester Frank	*Medico-Legal Affairs*
John D. DeWeese	*Academy-Education & Library*
Bruce B. Stoler	*By-laws*
James G. Fitzpatrick	*Medico-Religious Affairs*
Paul T. Moore	*Auditing*
Aaron M. Leavitt	*Impaired Physician*
Walter F. Tauber	*Tax Supported Medical Care*
Nancy L. Weiss	*Nominating*
William B. Coen	*Scholarship*
James F.X. Egan	*Public Health*

COUNCILORS

William J. Baker
John J. Bandeian
Eugene W. Beauchamp, Jr.
Nicholas P.W. Coe
John P. Fitzgibbons, Jr.
Garry deN. Hough, III
Edward W. Hughes, Jr.
John D. Izsak
Richard M. Kane
Robert J. Kasper
Lewis G. Lefer
Richard J. Miller
Paul T. Moore
Alan R. Munro
Franco Navazio
Terrence M. O'Neill
D. Sean Restall
George E. Reynolds
Gerry D. Ryan
Gulab K. Shah
Gregory A. Slachta
Lorne C. Smith
Philip B. Stoddard
Walter F. Tauber
Murray Watnick
Harrison D. Willcutts

John C. Syres	Ex-Officio	Allen S. Johnson
Gardner Cox, II	Ex-Officio	James J. Siragusa, Jr.
Augusto G. Asinas	Ex-Officio	William W. Walthall, Jr.

James J. Siragusa, Jr., President-Elect, Mass. Medical Society

THE HAMPDEN HIPPOCRAT

VOLUME XXXXII NO. 4
JUNE - JULY 1985

1414 STATE STREET
SPRINGFIELD, MASSACHUSETTS 01109
Telephone: 736-0661

THE HAMPDEN HIPPOCRAT is published by The Hampden District Medical Society Springfield, MA

Acceptance of advertising in the HIPPOCRAT Does not imply endorsement

Opinions expressed by authors are their own and not necessarily those of the Hampden District Medical Society.

About this issue...

The Publications Committee presents herewith the newly designed "Hippocrat" with what it hopes will be a more attractive and versatile format now and in the future. "New wine for new bottles" is necessary, though, and your letters, articles and opinions are still needed to fill these pages.

We introduce to you Barbara Rockett, M.D., the first woman President of the Massachusetts Medical Society. Dr. Asinas takes up his pen also, as President of this District Medical Society. Medical history may catch your eye, or the pictures of the annual meeting may cause you to pause for awhile. HMO's and PPO's are becoming more familiar, too. Remember that *The Hippocrat* is produced by and for the HDMS for information, challenge, and the pleasure of its members — a sort of rallying point for all of us in the ebb and flow of the medical world. ■

Diane DiPiero
is pleased to announce the opening
of the New Office of
Food and Nutrition Consignments
at 55 State Street,
Springfield, Ma.
offering a full range of
consulting services,
educational programs and resources
in food and nutrition for the
business community, industry,
advertising agencies, the medical
community, government agencies,
the media and the public.
Office hours by appointment.
Reasonable fees. For information
or an appointment,
please call 737-1935.
R.D.'s on staff.

SPECIALISTS

in malpractice insurance; excess liability; life, group, and health insurance; pension and profit sharing plans.

Henry F. Hanmer, *C.P.C.U.; C.I.C.,* **John L. Seyler**
Thomas T. Donahue, *C.P.C.U.,* **Stephen W. Fitts,** *C.P.C.U.*
Rod Goulding, *C.P.C.U.,* **Jay Josselyn,** *C.P.C.U.; A.R.M.*
Edward F. Hallet, Robert F. Wilson, Ralph A. Stirlacci

FE&B

FIELD, EDDY and BULKLEY, INC.
Insurance

1200 Main Street, Springfield • Telephone 413-733-3131

THE HAMPDEN HIPPOCRAT

CONTENTS

JUNE - JULY 1985

VOLUME XXXXII NO. 4

The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D., and William A.R. Chapin, M.D.

PAST EDITORS
Max Millman, M.D.
John C. Syres, M.D.
Walton E. Stevens, M.D.
Vivian M. Purdy

CONTRIBUTING EDITORS
Martin I. Broder, M.D.
Garry deN. Hough, III, M.D.
David W. Page, M.D.

PUBLICATIONS COMMITTEE
William J. Baker, M.D.
Nicholas P. W. Coe, M.D.
Terry D. Ryan, M.D.

IN THIS ISSUE

HDMS President's Message	6
MMS President's Message	7
MMS Leadership Conference	8
Toward The Surgical Academy – Flexner Revisited	12
Annual Meeting Report	15
CPR For Simonides?	17
Medicine Through The Years	20
Alternate Delivery Systems Buyer's Guide	22
Scenes From The Annual Meeting	28
Notes And Quotes Of Interest	29
S.A.M. Update	29
Hampden District Medical Society Auxiliary	30
Auxiliary Scholarship Award Winners	32
Welcome New Members	33
In Memoriam	34

THE HAMPDEN HIPPOCRAT is published bi monthly.
The opinions expressed in this bulletin are those of the writers and do not reflect the official viewpoint of the Hampden District Medical Society unless so stated.
All communications should be addressed to Carol L. Nystrom, Hampden District Medical Society, 1414 State St., Springfield, Mass. 01109: Telephone: 736-0661.
To be assured of uninterrupted delivery of THE HAMPDEN HIPPOCRAT, notify us in advance of an address change and include your zip code number.

HDMS President's Message

"United We Stand"

Augusto G. Asinas, M.D., President

I want to thank the membership of the Medical Society for having elected me as president for 1985-1986. In my eighteen years of neurosurgical practice in the Pioneer Valley, I have heard alot of complaints, bickering and indifference among our esteemed colleagues. It is high time that we put our differences aside and work for a common goal and that is for the betterment of our honorable profession. Let us band together and let it be known that we are united and strong.

The medical profession is confronted by many burning issues today that can either break or make us in the very near future. To mention a few; the medical malpractice, governmental control on medicare and medicaid, multiple delivery health care system, etc. We cannot and must not let these forces outside of medicine intimidate us. We will have to make some hard choices. We can work together and work we must within the system in order to better shape the future destiny of medicine. This will eventually benefit the general public and physicians alike. We can no longer afford to be in adverse position with the hospital administrations, insurance companies and even the legal profession but must find ways to bring our own learned and concerned colleagues together to solve the problem facing us. Let us join forces within the Medical Society to effect the change we sorely need.

I could find no other professional group so richly endowed with an intellect so noble and yet diverse but who cares greatly to help the sick, infirm and the needy. I enjoin and welcome all the members and those yet to be members of the Medical Society to be actively involved. Surely you would want to be part of the solution and not part of the problem! ■

BUSINESS SPOKEN HERE.

If you're in business, Bank of New England-West speaks your language.

Whether your business is large or small, wholesale or retail, high tech or insurance, domestic or international, Bank of New England-West has experts who understand your problems and who know how to help you find solutions.

Helping businesses grow and prosper is something we've been doing for over 100 years. In fact, Bank of New England-West is one of the reasons why today, Western Massachusetts has such a solid and diversified economic foundation.

But, as the largest commercial bank in this region, Bank of New England-West offers your business more than just experience, we offer a complete range of financial and business services, as well as the added convenience of your own Personal Banker.

So when you need the services of a bank, why not talk to the bank that speaks your language.

BANK OF NEW ENGLAND
WEST

MMS President's Message

Dr. Rockett Identifies the Issues

Barbara A. Rockett, M.D.
President, Massachusetts Medical Society

I am honored to serve as your President of the Massachusetts Medical Society for the coming year. Our profession is confronted with many issues facing Medicine in Massachusetts at the present time. Some of these issues are unique to Massachusetts, while others extend to all physicians across the nation.

Malpractice insurance premiums have been escalating and the JUA has recently won its appeal in court so that the 42% increase in premiums set by the Commissioner of Insurance for 1983-1984 has been remanded to the Commissioner for further upward adjustment consistent with the Supreme Judicial Court's opinion.

To address the problem of malpractice, the Society has filed ten tort reform measures, three of which have been reported favorably; namely, the bill which would protect the confidentiality of peer review proceedings, the bill requiring reporting by professional liability insurors to the Board of Registration in Medicine, and the bill raising the amount of the Tribunal bond from $2,000 to $5,000. The recent Supreme Judicial Court ruling demonstrates the necessity of enactment of the critical tort reform measures sponsored by the Society. The striking and repetitive increases in medical malpractice premiums makes professional liability one of our most important priorities.

Legislation that is unique to Massachusetts includes initiatives to guarantee access to care for indigent and senior citizens. Several "access" bills have been filed that propose requiring physicians to participate in Medicaid and Medicare as a condition of licensure and hospital staff privileges. The Massachusetts Medical Society has been addressing these access issues through negotiations with Medicaid and attempts to meet with Seniors' groups to learn more about these access problems.

The significant efforts of your district's Past President, Dr. Lorne Smith, and the Massachusetts Medical Society's President-Elect, Dr. James Siragusa, have contributed greatly to resolving your local problems of access to care. Your Society is also addressing these same problems throughout the state through its Department of Research and Development.

We are publicly opposed to mandatory participation in Federal and State entitlement programs as the solution to addressing "pockets" of access problems in Massachusetts. Legislation and various health programs have attempted to control the costs of medical care in this state. However, there is concern that these may prevent our patients from receiving adequate health care. We as physicians have a duty to our patients to provide them with the best medical care available. We must maintain a sense of respect for our patients. We must not forsake the medical ethics and principles we have been trained to preserve as a trade-off for cost containment in health care. The future of health care lies with us, and we must accept the challenge. We must build bridges with others and identify our allies in our quest for excellence in Medicine. As physicians, let's strive to keep Medicine in Massachusetts the best in the country. I am willing to work toward this end, and I ask for your help in the coming year. ■

MMS Leadership Conference

by Terry D. Ryan

On April 24, 1985, the Massachusetts Society sponsored a 1985 leadership conference entitled "challenges for today's physician". This program was held in Dedham, Massachusetts, and was attended by several hundred Massachusetts physicians, including six from our district.

After opening remarks from the president, Frederick Duncan, M.D., Arnold Relman, M.D., spoke on the medical-industrial complex. Dr. Relman's primary message was that we must beware of influences which would convert medicine into a strictly business enterprise and must make choices that will preserve our professionalism. In referring to the medical-industrial complex Dr. Relman was referring primarily to those large industrial organizations which are buying hospitals, and also are sponsoring "doc-in-a-box" offices, home health care organizations which threaten to put the VNA's out of business, building free standing NMR units, a strictly commercial enterprise, sponsoring commercially owned HMO's and getting into the health insurance business and even buying up medical practices. Dr. Relman told Massachusetts physicians that they are rather insulated from these problems to date because much of this has been going on in the sunbelt. He stated that the third party reimbursement systems which were developed in the 50's and 60's were developed on the assumption that medicine was a social service, neither a product to be marketed, nor a product whose consumption should be stimulated. The developers of these programs developed them on the assumption that the parties they would be reimbursing would be putting the medical care of their patients ahead of their own economic gain.

However, there were enough business oriented physicians who could see that the system could be manipulated and controlled for their own profit. Organizations bought hospitals in rich communities with healthy populations where the profits could be put into the pockets of the investors, rather than used to subsidize the care of the poor.

In response to this, the third parties are putting an end to cost shifting, philanthropy is disappearing, and the question is raised "Who will cover the cost of the care of the poor?" The business oriented hospital corporations have access to capital that non-profit hospitals do not have. In addition, they have many tax breaks, and up until now have been able to buy any hospital that they want. On investigation, one often finds members of the board of trustees with conflicts of interest in these financial deals. Dr. Relman itemized the effect of these changes as follows: 1) Loss of community control of hospitals, 2) Loss of future continuity in hospital management as hospitals are sold from one business organization to another to take advantage of tax write-offs, 3) A weakening of the voluntary system for care of the poor, 4) Tax supported system for care of the poor must be expanded, 5) It converts the medical profession into a business.

Dr. Relman concluded by stating that we must recognize that the political and economic climate will change and that we must behave as a profession and put the medical needs of society first, realizing that the economic rewards will follow. If we put the economic gains first, we will lose our status as a profession.

The second speaker was Dr. Dennis O'Leary. Dr. O'Leary is a Dean of Clinical Affairs and Acting Medical Director at George Washington University Medical Center in Washington. His theme was that in political action it is often wiser to formulate strategies for damage control rather than simply voicing opposition to legislation. He recounted a complicated political process whereby the privileges of nurse practitioners were being placed into law in the District of Columbia. From his point of view, the District of Columbia is the most liberal political climate in the country; even more liberal than Massachusetts. The local medical society realized that they could not prevent the licensing of any variety of non-physician practitioners. Through a long and complicated process of bargaining, both with the non-physician practitioners and with the local legislators, a bill was passed licensing such practitioners, but placing so many restrictions upon them that it was a highly ineffective bill.

The third speaker was John Zapp. D.D.S., the director of the AMA's Washington office and past director of the Congressional relations department for the AMA. Dr. Zapp began by stating that the strength in the federal level originates in an organization's ability to stimulate grass roots response. One of the key strategies is to avoid letting medical legislation splinter physicians into sub-specialties or small groups. The combination of a strong presence in Washington and a strong grass-

root movement are needed in order to have an effective voice with our legislators. Dr. Zapp stated that organized labor has not had a major piece of federal legislation passed in its favor in several decades in spite of the fact that it has over 70 lobbyists in Washington, because it has very little grass-root support. He went on to state that the legislative process has changed abruptly on some major issues from what the standard legislative process used to be. The Tefra legislation and the Medicare Assignment legislation were held up as examples of such changes. Both bypassed the normal legislative process and were basically decided in closed conferences. For any particular bill AMA staff members must now identify the 20 or so conferees that may make such decisions and attempt to educate the conferees on issues several months ahead of time if they are to be effective.

The final speaker who entitled his presentation "Fighting back: A new role for doctors" was Sanford Marcus, M.D., President of the Union of American Physicians and Dentists. Dr. Marcus is a surgeon practicing in Daly City, California, and has sparked much interest in a physicians union since his presentation in the NEJM six months ago. Dr. Marcus began his presentation by saying that he usually spends the first ten minutes of his talk outlining to his physician audience that "the sky is falling", but that his three predecessors in the program had already well informed the audience of that and so that he would begin on that premise. He noted that in addition to physicians' incomes falling, their loss of respect is falling more rapidly. He stated that physicians have fallen from a protected sphere of respect into a "Combat Zone".

If physicians are in a combat zone, who are their enemies? First, he noted the politics of envy--the attitudes of the 1960's rocked the pedestals of the mighty. We have been successful and thus our pedestal is being rocked. Second, he noted that 10% of the GNP is a "hell of alot of money". If an entrepreneur could skim 1% or 2% they would be rich and powerful. Items 1 and 2 pointed out the need for change for those who wish to practice the politics of envy and those who wish to skim from 10% of the GNP. To produce change you need a crisis and a health care crisis was invented. Health care was taking up 10% of the GNP while increasing military costs were taking up a similar

Continued on next page

"MEDICARE ASSIGNMENT? WELL I'LL BE..!"

Your patients' Medicare Card is good with us. Biomedics Corp. is concerned about your patients' well being. We realize the financial strain most of them are under. Consequently, we offer them advanced technology in the latest power beds; seat lift chairs; lightweight or power wheelchairs and we'll bill Medicare, Medicaid and Blue Cross directly. We do all the paper work. Medicare will pay us 100% for reconditioned equipment — your patient pays nothing. Hopefully, the next time your patients require hospital equipment, you'll tell them about Biomedics.

63 Main Street
Springfield, MA 01108
736-0376

BIOMEDICS CORP.

Springfield's Best Kept Secret

MMS Leadership

Continued from previous page

amount and 16% of the GNP was being spent on recreation and leisure.

"Do doctors want money?" he asked. "Yes," he responded to his own question, "but, not as much as ball players and airline pilots." In addition to that, doctors want the right to be the best doctor he can be without anyone on his back. Doctors need respect as much as money.

How to fight back? Doctors in Australia are on strike against National Health Insurance, but the difference is that antimonopoly laws are not in force there; they are in the United States. Dr. Marcus described the march on Albany, New York by physicians bringing attention to the malpractice problem that is more like collective begging than collective bargaining. He discussed the necessity of being an employee if you are going to join a union, but seemed to think the definition of an "employee" is rather loose. Trade unions are granted specific immunity from compliance with antitrust laws and painted the scenario describing a union which must direct all its efforts to the socio-economic good of its members. The AMA and MMS should take the high road and involve itself with medical standards while the union is fighting for the economic status and self respect of the physician, a "good cop--bad cop" scenario.

He warned of the potential of government breaking its contract with the elderly and the poor while placing the blame on us. We should not be placed in the position of saying "Mea Culpa" to a crisis that doesn't exist. In response to questions Dr. Marcus stated that implementation of a union in any particular state is very complex, but will occur when the problems in that particular state are sufficient to stimulate such an occurrence. A union exists to serve its members and must render a service. In California an insurance grievance mechanism has been implemented to help physicians obtain payment withheld by third parties. To date this has been its most significant contribution to physician well-being. In addition, it has worked in the area of helping physicians who are losing their medical staff privileges and helping to preserve physician's rights.

Dr. Marcus concluded by saying that nothing he says can convince physicians to form a union, that only the physician's own personal trauma can do so, and that his role is to point out to physicians the possibility of a union and to offer a format for organizing one. ■

E.F. HUTTON & COMPANY INC. OFFERS COMMISSION FREE PROFESSIONAL PORTFOLIO MANAGEMENT.

Hutton Consulting Services offers you the same professional money management services normally available only to large accounts. And to help your investments meet your objectives, your local Hutton Consulting Services representatives are backed by the vast resources and trading skills of E.F. Hutton nationwide. They also have access to a variety of financial data individuals normally wouldn't have. To learn more about Hutton Consulting Services, its fee structure and qualification standards, please call E.F. Hutton at 413-788-1400

EF Hutton

E.F. Hutton & Company Inc.
One Financial Plaza
Springfield, MA 01103

When E.F. Hutton talks, people listen.

Member SPIC

ATTENTION PHYSICIANS

PROFESSIONAL MEDICAL SYSTEMS

— INTRODUCES —

"THE PRACTICE"

MEDICAL MANAGEMENT SYSTEM

Features

- Patient Accounting
- Insurance Form Preparation
- Patient Recall
- Diagnosis Analysis
- Procedure Analysis
- 90 Days Direct Support
- Patient Encounter form
- Patient Statements
- Patient Supplemental Bill
- Patient Chart Labels
- Patient Mailing Labels
- Customization Available
- 7 Days 24 Hrs. Service Support

Hardware Used:

IMB-XT, IBM-AT, AT&T, IBM Compatible Products

Complete Package For Under $285.00/Mo.
(Lease)

For more Information or a demonstration please call collect or write to:

PROFESSIONAL MEDICAL SYSTEMS
16 Susan Drive
Suite 101
P.O. Box 1505
Westfield, MA 01086
Telephone: (413) 562-1457

* IBM is a trademark of International Business Machines Corporation * AT&T is a trademark of AT&T Information System * The Practice is a trademark of Medical Computer Software, Inc.

Toward The Surgical Academy - Flexner Revisited

By Paul Friedmann, M.D.

The following article is scheduled for publication in "Current Surgery."

The seventy-fifth anniversary of the publication of Abraham Flexner's famous study, "Medical Education in the United States and Canada" will be celebrated in 1985. Under commission from the Carnegie Foundation, Flexner focused on the problems of undergraduate medical education. He could not have foreseen the dramatic increases in the relative importance of graduate medical practice that have occurred in the past three quarters of a century. During the past 20 years, increasing attention has been directed to the quality and quantity of Grduate Medical Education (GME) in the United States. The Coggeshall report of 1965, the Millis Report of 1966, the Carnegie Commission Report of 1970, and the Report of the AAMC Task Force on GME of 1981 all addressed themselves to this issue. Common to all of these reports is the notion that the system of GME must be restructured and improved, and that responsibility for the post graduate education of physicians must be redistributed. The AAMC agreed in 1971 that "GME should ultimately become a responsibility of academic medical centers". The revision of the Essentials of Accredited Residencies by the Accreditation Council for Graduate Medical Education in 1982 has further defined institutional responsibility for the quality of programs in GME. However, much GME remains outside the direct purview of the Universities. The academic medical centers have not assumed responsibility for structure and content of educational programs during the residency years. The relationship between the medical schools and the teaching hospitals has remained in an uneasy balance, with each warily eyeing the other.

What should the role of the Universities be? As Sir William Osler stated in 1894, "A great University has a dual function — to teach and to think". It is to Osler that we are indebted for his emphasis on teaching — and learning — by the bedside in the hospital. It is to his surgical colleague at Johns Hopkins University, William S. Halsted that we are indebted for the introduction of the residency system from Germany into the United States. The model of medical education exemplified by Johns Hopkins University was very much in mind of Abraham Flexner. Whether his report stimulated change or was simply a catalyst for the acceleration of change already underway is controversial. It is clear that the emphasis of the report on the importance of basic sciences and research strengthened the position of the reformers and led to the closure of many marginal or inadequate medical schools. The report also stressed the role of the University in the expansion of knowledge and the need for university control of clinical teaching in hospitals.

The academic medical centers have not assumed responsibility for structure and content of the educational programs during the residency years. The relationship between the Medical Schools and the teaching hospitals has remained in an uneasy balance, with each party warily eyeing the other.

Undergraduate medical education since the Flexner Report has been standardized to the extent that all the accredited schools meet at least the minimum standards of providing a broad and comprehensive education in medicine. Since Flexner, however, there has been a profound change in the pattern of the practice of medicine. Some of the characteristics of this change have been the marked trend toward specialization and the proliferation of residency training programs in University and in non-University Centers, usually in response to service needs rather than academic needs. The Universities have not taken the lead in providing the academic base for post graduate education, and the primary efforts at controlling the quality of the process and the product have come from various specialty Boards, the Residency Review Committees, (RRC) and the ACGME. However, the format of the educational process has not been well defin-

ed. Furthermore the quality of the product is evaluated only in a retrospective manner by the specialty Board examinations. There is for instance, no mechanism for preventing individuals who have not learned enough to pass the Board examinations from practicing their specialties. The quality control mechanism of the Board examination is therefore ineffective where it is needed most, namely in assuring that graduates of accredited programs have successfully met all of the requirements of the Board. An important factor in assessing cognitive knowledge during the course of the surgical residency has been the development of the In-Training examination (ITE) of the American Board of Surgery. This examination has been the subject of debate, and controversy has surrounded its use. Virtually every residency program in the United States now requires its residents to take this examination, but there is no clear consensus about exactly how the examination should be used and what role it should play in decisions regarding the advancement of residents. Under pressure from the RRC, many programs use the ITE as the ultimate examination of the "one-room schoolhouse" which characterizes the academic structure of many surgical residencies.

One of the basic conflicts between the University and the teaching hospital is that in addition to teaching and thinking, the hospital must also provide service. Residents in surgery must learn how to provide that service and to learn "chirurgie," the "work of the hand." Surgical residencies must still retain some of the elements of the apprenticeship. There is no substitute for working with master surgeons and learning skills and techniques by observation and emulation. Surgeons must learn how to do, as well as how think and teach. How can we assure that the surgeons we train are competent and knowledgeable? Do we have an obligation to assure that those individuals who are competent technically but not knowledgeable, or vice versa, are not permitted to practice until they have become both competent and knowledgeable?

One of the ways to improve the acquisition of adequate knowledge on the part of the trainee is for the graduate education programs in surgery to assume more of the characteristics of the graduate school in the University, without necessarily giving up the benefits of apprentice-like technical training. Indeed, the thrust of the requirements of the ACMGE and the Residency Review Committees may hasten the emergence of a new surgical academy, which could have any one of the following characterstics. Graduate education programs in surgery will be structured in such a way as to provide a continuing, systematic, and comprehensive academic exposure to the field of surgery. This could take the form of course work, similar to graduate studies in other fields, and progression to higher levels of training will be dependent upon the successful completion of the basic academic work. In-Training examinations will continue and could be made an integral part of the credentialing process. All surgical trainees will be exposed to an organized core curriculum prior to passing on to advanced levels of training in general surgery or on to further training in a surgical specialty. All trainees in surgery should make a contribution to medical knowledge in some fashion, either in a form of a completed research project or of a thesis. An academic degree may be granted by an accredited institution upon the completion of training. Graduate education in a dicipline such as surgery is no less deserving of academic recognition than graduate education in any other field of knowledge.

The American Board of Surgery will continue to

Continued on next page

Message Center Beepers
1401 State Street, Springfield, MA 01109
Mobiletelephone ■ Beepers ■ Answering Service
781-1149 **Mass** Toll Free: 1-800-332-1149

Flexner Revisited

Continued from previous page

serve in a pivotal role in the surgical academy. The Board will continue to set national standards for certification of surgeons. However, the examinations should be given earlier, prior to completion of the training period. NO individual who fails the Qualifying examination should be considered to have completed his residency training, and he should recieve neither a certificate nor a degree from his institution until he passes the examination. Alternative pathways have to be found for individuals who fail the examination, in order for them to achieve a satisfactory level of skill and knowledge in order to pass the examination.

Where do the non-university hospitals fit into the scheme of graduate surgical education? The AAMC suggests that all such hospitals either affiliate with academic medical centers, who would then presumably assume full responsibility and control, or become free standing schools of graduate medical education. There are some non-university centers which have programs of such high quality that they can, themselves, qualify as graduate schools of medical education, and these institutions should so be recognized. It is not realistic to prohibit all non-university hospitals from conducting programs in graduate education. For one thing, the educational programs of some of these institutions are equivalent to those of many universities. Furthermore, many community or non-university hospitals have access to a broader variety of patients, more accurately reflecting the incidence patterns of disease, than many University hospitals, which have developed principally as tertiary care or referral institutions. There is clearly room for both types of institutions in any program of graduate medical education. Many universities have taken this into account and have taken the lead in establishing close affiliations with community teaching hospitals for the purposes of enhancing both their undergraduate and graduate teaching capabilities, and enhancing their clinical base. Of the 309 hospitals sponsoring surgical residency programs listed in the Directory of Residency Training Programs for 1984-1985, 241 (78%) are listed as having a major affiliation with a medical school. That means that the hospital is considered by the medical school to be an important part of the teaching program of the school and to be a major unit in the clinical clerkship program. A hospital with a major affiliation will participate in any graduate medical education programs of the medical school. 13 hospitals (4%) are listed as having graduate affiliation only, 54 hospitals (17%) have limited affiliation, and only one hospital is listed as having no medical school affililation. Even though there is considerable variation in the details of any affiliation between the medical school and the teaching hospital, the fact that such affiliations are so ubiquitous is an indication of the importance attached to them by both parties. The University can provide the matrix and the framework within which the teaching hospital can flourish.

The process of academization of the surgical residency is an inexorable one. It had its roots with Flexner, but now derives its impetus not only from academic and educational concerns but also from profound social and economic forces. The manpower implications of the GMENAC report cannot be ignored and need to be faced openly. The pressure to reduce medical care costs and, by implication, the costs of graduate medical education will be a dominant theme for the future, and will have to be reckoned with. The interests of the medical school, the teaching hospital, and society at large are closely intertwined, and no one can escape from the others. It will take the combined efforts of all of these concerned groups to reach acceptable conclusions about maintaining the quality and integrity of graduate medical education. For all of us involved in graduate surgical education, the academy will play an increasingly important role. We are probably not far from being able to say, to metaphrase the immortal statement of Walt Kelly's Pogo, "We have met the academy, and they is us". All of us. Flexner, no doubt, would approve. ■

MARY LYON NURSING HOME
Hampden
Massachusetts
MEDICARE APPROVED
Phone: 566-3431
566-3426

Annual Meeting Report

The 145th Annual Meeting of the Hampden District Medical Society was held on Tuesday, April 23, 1985 at the Carriage House of Storrowtown Tavern in West Springfield. There were 135 members, spouses and invited guests present.

Dr. Smith, President, called the meeting to order at 6:10 p.m.

The minutes of the January 29, 1985 meeting were read by Dr. Walthall, Secretary, and approved by the members as read.

Dr. Remsberg, Treasurer, gave the financial report, which is on record at the Hampden District Medical Society and the Academy of Medicine and said the finances were in order.

The report of the Nominating Committee was read by Dr. Smith for Dr. Reynolds, Nominating Chairman. Motion was made, seconded and passed to accept the report. The Secretary was instructed to cast one ballot. Dr. Smith announced there was one Council slot open and asked anyone interested in becoming a Councilor to contact Dr. Asinas. Dr. Beauchamp presented the new slate of officers for the Academy of Medicine.

Motion was made, seconded and passed to accept the reports of HDMS Committees as published in the April/May issue of The Hampden Hippocrat.

Drs. Baker, Coe and Ryan were given a vote of appreciation for the fine work they have done on The Hampden Hippocrat.

Dr. Smith reviewed his year as President, including meetings with Commissioner Hurst of the Commission Against Discrimination and the Medicaid Access Coalition. Dr. Smith said JUA Malpractice Insurance will be an important issue in the coming year. He asked the membership if they had interest in setting up an off-shore excess malpractice insurance company. The majority of the members expressed interest and Dr. Smith will investigate this further.

Dr. Smith announced that MMS will send a letter to all members regarding the status of the Blue Shield Suit.

Dr. Fitzpatrick announced that the Academy of

Continued on next page

$.....

THE BOTTOM LINE
IS GETTING PAID!

PAID FOR YOUR SERVICES • PRODUCTS

WE ENHANCE BOTTOM LINES
through professional
COLLECTION SERVICES

ETHICAL • EXPERIENCED • EFFICIENT
BONDED

for further information
785-5800

HART ADJUSTMENT BUREAU

1355 LIBERTY ST., SPFLD., MA 01104

Annual Meeting Report

Continued from previous page

Medicine Paintings will be on display during dinner. Contributions to pay for commissioning an artist to paint another painting depicting a physician of the 80's would be welcomed.

Dr. Terry O'Neill presented a legislative update and a slide presentation of the malpractice bills filed by Mass. Medical Society.

The Business Meeting was adjourned at 7:00 p.m.

A brief Councilors' Meeting was held. Dr. Hough resigned as Executive Councilor. Dr. Philip Stoddard was elected to replace him. Dr. Terry Ryan was elected Alternate Councilor.

Following a cocktail hour and dinner, Dr. Smith thanked Mrs. Vicki Kiss, outgoing Auxiliary President, for a year of fine work by the Auxiliary. Mrs. Pat Smith and Mrs. Susan Panitch were given a vote of thanks for the excellent, healthful meals they planned for the District Meeting.

Dr. Smith called for a moment of silence for deceased members.

Drs. Barnes, Hahn and Hosman were honored for having completed 50 years in medicine. Drs. Barnes and Hosman were present to accept their certificates.

The names of twenty-eight new members were read by Dr. Smith.

Dr. Smith introduced Dr. Augusto Asinas, new President. Dr. Asinas presented Dr. Smith with a placque and thanked him for his fine leadership during the past year.

Dr. Smith introduced Mr. John K. Springer, President of Hartford Hospital and Dr. Roger Beck, President of Hartford Hospital's Medical Staff. Mr. Springer and Dr. Beck discussed the Connecticut DRG Experience.

Dr. Smith thanked Mr. Springer and Dr. Beck for their informative talks.

The meeting was adjourned at 9:45 p.m. ■

Respectfully submitted,
WILLIAM W. WALTHALL, JR., M.D.
Secretary

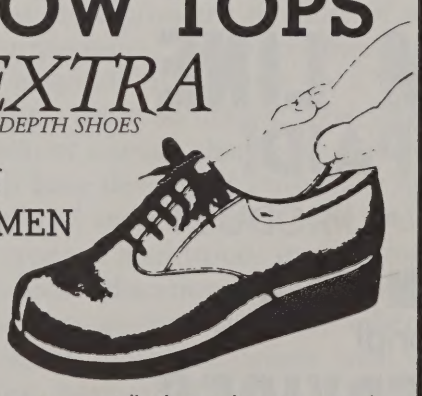
Benefit From Years of Expert Shoe Fitting at ARNOLDS

CRADLE YOUR FOOT IN SOFT DEERSKIN

PILLOW TOPS

THE *EXTRA*
REG. U.S. PAT. OFF. *DEPTH SHOES*

FOR MEN
AND WOMEN



Other Styles
Available

- Extra Depth Shoes are especially designed to give natural support to the arches of the foot.
- Perfect for Post-operatives, people suffering from weak arches, bunions, hammer toes, enlarged joints or metatarsal discomfort.
- These Lasts are ¼" deeper, allowing room for our special cushioned inlay for super comfort, which is easy to customize. Or remove the inlay to accomodate molds or arches.

"Put Your Feet In Reliable Hands"

ARNOLD'S
Foot Health SHOES

FREE
PARKING

327 BRIDGE ST., OPP. STEARNS SQ.
Open Mon. & Thurs. Nites

PROFESCO
of Holyoke
489 Whitney Ave.
Holyoke, MA

PROFESCO

FINANCIAL PLANNING

FOR THE PROFESSIONAL

"We Specialize In Planning For Interns & Residents"

- Building Construction and Design
- Disability Income Planning
- Equipment Loans
- Leasing
- Life Insurance Premium Financing
- Personal Loans
- Accounting & Billing Systems
- Tax Advantaged Investments

Phone (413) 534-4583

Albert J. Galeassi or Claude Bell
Account Executives

CPR For Simonides?

by David Page, M.D., F.A.C.S.

On a day-to-day level physicians constantly struggle with new information, the ultimate fact managers in a runaway information society.

It is said that the Greek lyric poet Simonides invented the mnemonic art. Other ancient teachers of rhetoric, including the Elder Seneca — who reportedly reveled in recalling lengthy speeches long after he had heard them — spent endless hours cultivating their memories. Cicero declared, "Memory is the treasury and guardian of all things." Thus, long after the appearance of the printed word, physician and poet, lawyer and lyricyst, priest and professor continue to rely on recall.

Without a doubt, medical practice highlights the unmitigated expansion of man's information base more than any other intellectual endeavor. Since the "big bang" of dawning consciousness, facts have accumulated, necessitating the invention of the computer. Yet, on a day-to-day level physicians constantly struggle with new information, the ultimate fact-mongers in a runaway information society. Implied in this run for the academic roses is a moody, unpredictable shift in emphasis: what is important today becomes overshadowed by innovation tomorrow. Presumably, no two doctors possess the same information base. This notion is supported by the volume of data available as well as the documented shifts in medical school curricula over succeeding decades of this century. Modern medicine is a spirited, adolescent chameleon.

The 1910, 18th edition of *Gray's Anatomy* contains a publisher's note which describes the text, printed half a century earlier, as "...incomparably the greatest textbook in medicine." Swollen to fourteen hundred and ninety-six pages, *Gray's* offers many a mnemonic challenge to the fledgling medical student. "On old Olympus towering top...", "Timothy doth vex..."; the list of mnemonics used in anatomy alone runs on like the tides of Fundy, flooding the memory with facts, only to surge back with more recollected information. Anatomic details filled a major part of the early medical school curriculum. Afterall, there wasn't much to learn before the era of immunology, infectious diseases, electronmicroscopy, detailed physiology, electrocardiology, organ transplantation, multispecialty cancer care, not to mention the legion of sub-specialty niches. Now, medical data swarms over the practice, marring the art. A startling example is Devita's *Cancer: Principles and Practice of Oncology,* over nineteen hundred pages which apply to virtually all aspects of medical care. At the same time, our desks tremble beneath the layered load of journals, reprints, clinical charts. Data overload has begun.

What pleasure Simonides might have enjoyed if he returned now to frolic in our medical libraries, setting his mnemonic traps for the skitterish prey so elusive to the twenty-first century physician. How much data could he memorize before he too would throw up his hands in desperation and cry, "No more! Please, no more facts!" If the medieval scholars were alive today where would they halt the measure of a physician's knowledge? Would memorizing become an art form once more or would the doctor become derailed in the attempt, derailed in a hail of aberrant, multifocal brain spasms? Was Montaigne correct in declaring, "...a good memory is generally joined to a weak judgement?"

Imagine the remarkable Russian Shereshevski who committed to memory massive tracts of information, then, demonstrated his ability to recall the data flawlessly, in forward or reverse order as long as fifteen years later. His performance has been documented by one no less reliable than Dr. Alexander Luria, who noted that when Shereshevski became overwhelmed by the sheer mass of facts he had learned, he retreated to sanity by imagining the facts being erased from a chalkboard, thus clearing his mind. Equally stunning is the performance of world class chess players. When permitted a five second glance at a chessboard set-up they could recall eighty percent of what they saw "as a whole." Adriaan de Groot, the Dutch psychologist who performed this experiment, demonstrated that average chess players could recall only forty percent of what they observed in a five second view of the board.

Thus, on the one hand our rich medical inheritance, coupled with an on-going mad dash for new information dictates a need for efficient data storage and retrieval. Yet, most of us are "forty percenters", possess mediocre information banks.

Continued on next page

CPR For Simonides?

Continued from previous page

Herman Ebbinghaus, the first scientist to become interested in the study of memory, intimated that "you get what you pay for": you remember a quantity of data commensurate with the time investment devoted to learning. Studies in the emerging field of memory research suggest: 1. memory decay curves level out in time and resist further erosion; 2. we re-construct past events according to our attitude toward them; 3. short and long-term memory are probably different; 4. forgetting is a prerequisite to sanity. The physician is seen defending him or herself at a mortality conference, against the slings and barbs of utilization, PRO, or the sting of litigation, recalling a different scenario of the patient's clinical course, perhaps at odds with the recollection of another physician, and, perhaps, the written record. In the end, the physician must escape into uncertainty. "I don't recall," he mutters. The keen edge of sanity at last slices through the burgeoning, paper swamp of medical practice. The stooped physician shuffles out of the hospital, grimacing and muttering, "Computers are winning."

Yet, the physician knows that most diseases have not changed at all, not since the scourges know to paleopathologists which are still treated today. It is the mitotic swell of *new information* that engourges data banks, showing off as though staid, time-tested medical knowledge had shrunken. Are there clues in the practice of medicine which belie the dilemma of remembering? Clues lie scattered all about us. Recall is the bayonet in the effete game of intellectual sparring. Flippant rejoinders become the garrotes intended to silence the enemy in the bloody auditorium mouth-to-mouth combat. Machinegun reference-quoting sounds against the snipping of "personal experience." In the end, the wordfight crescendos to the earsplitting cannonade, pressed into battle in desperation, "*...when I was a resident!*" True memory, accurate recall, that evaporative mist, slinks from the insult strewn battlefield in predictable defeat.

This destructive bent, often observed in medical displays of expertise, may borrow from what are actually useful devices to enhance recall. Beyond the desire to remember and the apparent need to quibble over detail are specialty review courses, abstracts, springbound synopsis, and endless mnemonics, the phrase fragments designed to enhance recall. In the desperate, pitched battle of real dis-

Important products from Dista

Nalfon® 600-mg* Tablets
fenoprofen calcium

Keflex® 250 and 500-mg Pulvules®
cephalexin 125 and 250 mg per 5 ml, Oral Suspensions

*Present as 691.8 mg of the calcium salt of fenoprofen dihydrate equivalent to 600 mg fenoprofen.

Additional information available to the profession on request.

DISTA
Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285

420080

ease, multi-system trauma for example, the ABCDs must be recalled and employed in resuscitating the dying victim. Indeed, the seasoned physician teaches with humility, challenges with reservation, corrects with doubt, and quotes with reservation.

What shall we do with our legacy of facts?

One potential answer is to divide *all* medical information into two categories: **elective** or **emergent.** Although overlap will occur, as a basic tenet, information can be considered with respect to its immediacy, its impact on a disease process. The physician would be expected to use the Simodean principle of memorizing — using mnemonics — to freeze vital facts in one's mind. Retrieval in the heat of resuscitation and emergency care would be the solitary goal of purposeful memorizing. All non-emergent information would be considered elective, and thus we might well defuse the intimidating confrontations which characterize resident learning, medical student "grilling" sessions, fundamentally designed to embarrass the fledgling doctor. It ought to be sufficient to be able to recall emergent information. Anything else is a bonus. At a time when physicians are being reduced to mere stretcher bearers inthe final common pathway of health care provision, we must be proud of what we know, not embarrassed in the certainty of what we do not know, cannot know.

The multiple trauma victim represents the ultimate challenge to the surgeon. It matters little to the patient if the surgeon knows in minute detail the subtleties of high-level PEEP if he misses a tension pneumothorax in the emergency room. A gifted knowledge of growth and development does the ten year old no good if the pediatrician sends the child home with a perforated appendicitis labelled flu. And, as always, it is the medical student who stands mouth agape at the end of the fact funnel, brain trembling like an overloaded biceps. Only when he becomes a seasoned clinician will he learn our truth: it cannot be done. The facts are too numerous, and it is the sturdy walls of our specialties that we hide behind as we toss our information recklessly. It is time to retreat into sanity, not through forgetting alone. But, through a conscious effort to stratify information and commit to memory only those facts which the emerging clinical course will not permit time to relearn.

Above all, the physician must be a first responder, no matter the specialty. Revive Simonides! Bring back the art of mnemonics. A catchy jingle in every gray cell. Let medical literature broaden our perception, not distort it. If we are to avoid becoming mere "providers" we must return to the laying on of hands. Afterall, the stethescope is nothing if not an extension of our nervous system, the grandest computer of all. ■

Henderson's Funeral Home

Distinctive Dining at Springfield's
STUDENT PRINCE
and
FORT RESTAURANT
6 Fort St. 788-6628-Springfield

TOROS OMARTIAN & SON, Inc.
We Buy and Sell
ORIENTAL RUGS
286 Bridge Street
Tel: 736-1531
Open Thurs. til 9:00 p.m. *Free Parking Validated*

Medicine Through The Years

by Margaret Stoler, Springfield Academy of Medicine

In conjunction with the 1986 Physician Portrait Fund Drive, a series of articles will appear in the Hippocrat giving an overall view of the development of medicine from the colonial period to the present.

1636-1686, The Clerical Doctor

Medicine in the early colonial period was far more specialized than you may think. From the barber who would gladly amputate, to the tavern owner whose concoctions were sure to cure or kill, to the minister-physician, who always carried his bottle of leeches, carefully corked, of course, the inhabitants were well cared for, with never any concern for over-population.

In all fairness, the educated minister was the greatest source of medical knowledge in the 17th century. Though several physicians were solicited by the Mass. Bay Company to serve the colony,none remained longer than the required three years, so the task of maintaining a healthy community was left to the minister and to God, and everyone was well aware who had the upper hand. Epidemics were the sign of God's wrath and all the minister could do was to hold fasts and pray.

One outstanding exception to the minister-physician was Samuel Fuller who was a deacon and arrived on the Mayflower. He settled in Plymouth and traveled throughout the colonies tending the sick, frequently serving as a liason between the bickering colonies such as Plymouth and Salem. Following his visit to Salem in 1629, Gov. Endicott wrote to Gov. Bradford of Plymouth, " I acknowledge myself much bound to you for your kind love and care in sending Mr. Fuller among us, and rejoice much that I am by him satisfied..."

Samuel Fuller died in 1633. His son, Matthew, served as Surgeon-General for the provisional forces in Plymouth in 1673.

The Rev. Dr. Thomas Thatcher, pastor at Old South Church in Boston in 1669, devoted much of his time to the practice of medicine and was regarded by his fellow colonists as the most eminent physician. Towards the end of his life in 1677, he published a paper on small pox and measles which is considered the first medical paper published in the colonies.

One of the outstanding minister-physicians was the Rev. Gov. John Winthrop, as well as his son, John Jr. His manuscript is preserved at the Mass. Historical Society and contains some of the following remedies which were acquired by Winthrop from Dr. Ed Stafford of London:

> "For ye falling sicknesses - purge first with extract of Hellebore...and God Willing he shall be perfectly cured in short or longer tyme according as the disease hath taken root.
>
> For breast pain - wear a wild cat skin on the place grieved.
>
> Small pox - In the month of March, collect as many toads as necessary and place them in an earthen pot, turn the pot up side down and set on fire, when cool, remove the toads and pound until of powder consistence, mix with a "drayme" of hot water and drink. This remedy would also cure gangrene, ulcers, cankers, fistulas, and "Kings Evill."

Aside from the so called prescribed care, each minister-physician had his own methods for success. For instance, the Rev. Samuel Swift published a broadside in 1667 concerning female problems. His remedy; "If you see her Face in Her water, if she have not a fever, she is with child...if the urine is Bright and Gold the trouble with the patient is Lust or desire to Marry." He also recommended bathing severe burns with the blood of a newly killed cat.

An early explorer, John Josslyn, though not a minister-physician, had his own views on health remedies and couldn't speak highly enough of the wondrous effects of tobacco, claiming it "helps digestion, the Gout, the Tooch Ach, prevents infections, it heats the cold and cools them that sweats, feedth the hungary....Immoderately taken, it dryesth the body, inflammeth the blood, hurteth the brain, weakens the eyes and sinews". Wouldn't R. J. Reynolds love to have him in their

PR department.

Although mothers used various cures handed down from generation to generation, women's role in medicine during this period, was practiced mostly in the field of midwifery. Those who dared challenge the authorities were eliminated. Ann Hutchinson was banished from the colony in 1661, not only for her Antonian leanings but for producing medicinal remedies which was attributed to the birth of a badly malformed infant. Jane Hawkins was banished in 1641 "for Practicing physicks" and Margaret Jones was hung as a witch because her "potions were too good and cures too wonderous ...a sign of dealings with the Devil."

There were several cases in which women were honored for their midwifery. Bridge Fuller, wife of Samuel Fuller, was invited by the colony of Roxbury to reside with them with "all physical wants provided" but she chose to remain in Plymouth until her death in 1663. Elizabeth Philips in Charlestown was credited on her tombstone with bringing "into this world above 3000 children." There does exist one tribute to a woman physician; that was to Sarah Alcock who resided in Roxbury where in 1665, the church records state she was "A Virturous woman skilled in physicks and chirurgery."

There were, of course, many charlatans, the most famous being Nicholas Knapp who, in 1631 was fined and whipped for pretending to cure scurvy with "water noe worth no value which he sold at a very deare rate," The indians were successfully curing scurvy with a mixture of boiled cranberries long before the colonists arrived but who would believe an indian.

Perhaps the most accurate description of the practice of medicine in 17th century New England is best expressed in a poem written in 1662 by the Rev. Michael Wigglesworth:

Our healthful days are at an end,
  And sicknesses come on
From yeer to yeer, becaus our hearts
  Away from God are gone --
New England, where for many years
  You scarcely heard a cough
And where physicians had no work,
  Now finds them work enough
Now colds and coughs, Rheums and sorethroats
  Do more & more abound:
Now Agues sore & Fevers strong
  In every place are found.
How many houses have we seen
  Last Autumn, and this spring,
Wherein the healthful were too few
  To help the languishing.
One wave another followeth,
  And one disease begins
Before another ceases, becaus
  We turn not from our sins --
We stopp our ear against reproof,
  An hearken not to God;
God stops his ear against our prayer,
  And takes not off his rod."

1986 Physician Portrait

In 1986, the city of Springfield will be celebrating its 350th Anniversary. In response to the city wide celebration, the Springfield Academy of Medicine is planning to add another painting to their present collection which depicts the changes occuring in the field of medicine every 50 years beginning in 1636.

Consequently, the Academy is starting a fund drive towards creating a new painting depicting the changes in the field of medicine since 1936. Your help is badly needed and will be greatly appreciated. Please make your donations payable to *1986 Physician Portrait* and mail it to:

Dr. James Fitzpatrick
Springfield Academy of Medicine
1400 State Street
Springfield, MA 01109 ■

GREATER SPRINGFIELD HEALTH CARE COALITION

Alternate Delivery Systems Buyer's Guide

Prepared by The Alternate Delivery Systems Committee

GENERAL CHAIRMAN
Seymour Sternberg, CLU
Massachusetts Mutual Life Insurance Company

HMOs

Vice Chairman
Dr. William Baker Monarch Life Insurance Co.

1. Anthony Mott Rep. of Baystate Medical
2. James Sleeth Rep. of Medical West
3. Kelly Erwin Valley Health Plan

PPOs

Vice Chairman
Maureen Skipper Visiting Nurse Assoc. of Springfield, Inc.

1. Stephen Corbett Rep. of Mercy Hospital
2. Bruce Suchy Rep. of Pioneer PPO
3. Janett Greenberg Massachusetts Mutual Life Ins. Co.

The *Hippocrat* editors believe that this document is of sufficient interest to HDMS members to be published in its entirety. Section I and II are included in this issue and the remaining sections will appear in future issues.

INTRODUCTION

Over the last decade, rapidly rising medical care costs have led to the development of alternative delivery systems such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). These alternatives to traditional insurance are gaining increased popularity as mechanisms to help employers hold down health insurance costs. Surveys have shown clear and positive consumer acceptance of alternative delivery systems. This has been reflected in the rapid growth in the numbers of HMOs and PPOs, as well as in enrollment growth.

As these alternatives become available in more geographic areas, it becomes extremely important that corporate decision makers become more knowledgeable about them. This is the case in Western Massachusetts where these alternatives not only exist, but have grown in size, number and popularity.

This Alternative Delivery System Buyer's Guide was developed by the Greater Springfield Health Care Coalition to both educate corporate decision makers about these alternatives and to provide them with comparative information and useful questions to ask when selecting an HMO or PPO to offer their employees. Because this guide is directed towards alternate delivery systems, it does not attempt to describe traditional health insurance programs. It is assumed that the reader has a reasonable familiarity with this form of health care delivery.

The guide is organized in four sections. Section I defines and describes Health Maintenance Organizations (HMOs): their history, growth, and regulatory environment. It explains various types/models of HMOs, and summarizes characteristics common to all models, as well as features which differentiate them.

Section II defines and describes Preferred Provider Organizations (PPOs): their history, growth, and regulatory environment. Because there are no discrete PPO models, it explains variations in key program design and structural features which may exist between PPOs.

Section III is a Buyer's Guide which is intended to function as an evaluation aid to the corporate decision maker. It provides comparisons between HMOs and insured plans, PPOs and insured plans, and HMOs and PPOs. It also provides lists of questions which could be asked to assist in the selection of the best HMO and/or PPO.

Section IV describes HMOs and PPOs currently available in Western Massachusetts.

I. HMOs

Definition

An HMO is a health care organization which combines the delivery and financing of medical services. Services are delivered on a prepaid, capitated basis. This means that on a prospective basis a fixed price per head is established for which the HMO will provide all medical services

covered under the terms of the contract.

Because HMOs both deliver and finance medical services on a prepayment basis, patients are not billed on a fee-for-service basis, and therefore, do not submit claims for services rendered. Rather, they typically pay a "service" charge (fixed copayment amount) each time the HMO is used.

Background, Growth, and Regulatory Environment

The first health maintenance organization on the east coast was established in 1937. The concept grew slowly until the 1970's at which time escalating health care costs began to gain national attention, particularly in the public sector, and the potential of HMOs to control medical costs was noted.

In the early 1970's the federal government sought to promote the development of alternative methods of providing quality medical care in a controlled environment. HMOs were such an alternative, and so, the government began to subsidize their development by providing "seed" funds.

The success of these operations spurred the rapid growth and proliferation of HMOs throughout the country over the last ten years. In 1970 about 30 HMOs were serving 3.6 million Americans. By June 30, 1984 there were 311 HMOs with nearly 15.2 million enrollees.[1] In Massachusetts 20 HMOs now service more than 600,000 members, or in excess of 10% of the state's total population.[2] Locally, two HMOs have a combined membership of more than 77,000 people. HMO success and public acceptability have led to a recent trend toward use of HMOs to provide services to Medicare and Medicaid eligibles.

From a federal regulatory standpoint, HMOs are enabled to exist anywhere throughout the country subject to specific state regulation.

Massachusetts, under Chapter 176G of its General Laws, sets the requirements for licensure of a Health Maintenance Organization with the Commissioner of Insurance delegated to issue licenses and administer the requirements set forth in the HMO's Evidence of Coverage. The HMO must have the financial stability to provide the services and maintain solvency as well. A Massachusetts based HMO must be licensed in conformity with 176G to seek federal qualification, but the latter is

Continued on next page

We call on Doctors at East Longmeadow Nursing Home

Professional coordinator available to meet with you **in your office** to discuss any of your patients **prior to admission.** And as always we excel in

- 24-Hour Registered Nursing Care
- Physical Therapists to Continue Your Prescribed Therapy
- Special Dietary Requirements Graciously Served
- Luxury Accommodations are available at our Longmeadow House

East Longmeadow Nursing Home & Longmeadow House

305 Maple Street
East Longmeadow, Massachusetts

413-525-6361

Hannover Healthcare, Inc.

Alternate Delivery Systems Buyer's Guide

Continued from previous page

not necessary for State licensure.

Federal qualification is equivalent to receiving the "Good Housekeeping Seal of Approval." To be federally qualified, the HMO must fulfill the requirments of the HMO act of 1973, outlining legal structure, mandated services, premium rates, fiscal liability, insolvency protection, quality assurance programs, etc. Also, the Act provides for ongoing compliance and monitoring systems, failure of which to observe may cause an HMO to lose its "qualified" status. In Massachusetts 55% of HMOs are federally qualified as compared to 70% nationally.

Receiving federal qualification assures employers that the HMO being considered has met federal standards. It also provides the HMO with a marketing edge, in that employers of 25 or more employees who reside in the HMO service area must by law offer that HMO as a health insurance option to employees prior to the beginning of a new plan year. This period of time prior to the beginning of a new plan year when employees choose to enroll in the HMO or the indemnity plan is called "open enrollment." Offering the employee the choice of participating in the traditional insurance plan or the HMO during open enrollment is what is referred to as dual choice. HMOs are an *alternative* to traditional insurance. There is no law which prohibits an employer from offering an HMO or more than one HMO program as the *only* alternative(s) for health protection. If there is more than one federally qualified HMO plan in a service area, the employer is only required to offer one plan of each type—IPA and closed panel.

HMO Models/Types

Despite variations, there are essentially two types of HMOs:

1) Group or Staff Model—both frequently referred to as a closed panel HMO; and
2) Individual Practice Association (IPA)—frequently referred to as an open panel HMO.

Group Model - A group model HMO is one in which the HMO hires or contracts a group of physicians and other medical support personnel to deliver services at one or more specific locations. These locations typically house laboratories, x-ray equipment, and pharmacies, although some of these services may be contracted for with "off-site" providers.

Some group models, such as the Kaiser-Permanente group in California, own their own hospitals where inpatient services are provided to their members. More commonly, these models use local hospitals. Some negotiate special reimbursement arrangements with specific local hospitals; others buy hospital services at the market rate.

Individual Practice Association (IPA) - An IPA model HMO contracts with a number of doctors who practice in their own offices and see HMO members there. Many also contract with other private health care providers, such as laboratories, pharmacies, home health care organizations, etc. to provide the full range of services offered under their contract.

FOR EVERYTHING IN TRAVEL!
AGENTS FOR LEADING AIRLINES, HOTEL & STEAMSHIP COMPANIES
DOMESTIC & FOREIGN TRAVEL
TRAVEL AGENCY
ARRANGED FOR BUSINESS OR PLEASURE
FULLY COMPUTERIZED RESERVATIONS & TICKETING SYSTEMS
Weidner Travel, Inc.
JOE MELL President
Everything in Travel
ANYWHERE IN THE WORLD Call 781-0550
131 DWIGHT ST. SPRINGFIELD (OPPOSITE CIVIC CENTER GARAGE)

Most commonly, these models use local hospitals. Some negotiate special reimbursement arrangements with specific local hospitals; others buy hospital services at the market rate.

NOTE: Over the last few years there has been a trend toward hospital owned/sponsored group and IPA model HMOs. In hospital sponsored/owned HMOs, both inpatient and ambulatory laboratory and radiology services are provided at the sponsoring facility. Specialty services or services not available in a given hospital are purchased outside, as is the case with HMOs of other sponsorship.

Both models usually provide at least the following basic services:

- Physician's services, including consultation and referrals, without time or cost limits;
- Medically necessary inpatient and outpatient hospital services normally supplied by hospitals;
- Diagnostic laboratory, x-ray, and therapeutic radiology;
- Emergency health care services, both in and out of the service area;
- Up to 20 outpatient mental health visits;
- Home health care services;
- Preventive health care, including family planning, eye and ear examinations, immunizations, periodic health examinations for adults, and well-baby care.

Many HMOs also include or offer as options coverage items such as:

- Prescription drugs
- Adult eye examinations
- Dental Care
- Intermediate and long-term care
- Extended mental health care
- Rehabilitative services including physical and occupational therapy.
- Prenatal classes
- Post-coronary classes
- Smoking cessation
- Nutrition
- BP screening
- Stress reduction

Summary of HMO Characteristics

As noted, there are two forms of health maintenance organizations—group or staff model, and IPA (Individial Practice Association). They are similar in most characteristics. All are organizations that combine the delivery and financing of medical services, offering a broad package of such services on a prepaid basis to voluntarily enrolled groups of members.

Similarities

1. Annual capitated premium
2. Comprehensive range of services offered
3. Little or no co-payment
4. Some restriction on consumer choice - limited to participating providers
5. Defined and monitored system of utilization control
6. Provider risk sharing with accompanying incentives to control volume

Differences

1. Delivery site
   Group/Staff - medical services are delivered in one or a small number of sites.
   IPA - medical services are delivered in the private offices of all participating physicians and other contracted provider sites

2. Provider Reimbursement
   Group/Staff - primary care physicians, certain specialists are on salary or capitation
   IPA - primary care physicians are characteristically on capitation with specialists on negotiated fee-for-service. Some IPAs have all physicians on negotiated fee-for-service, but a percentage of fees is retained in an HMO "pool" which is then distributed back to participating providers annually if a surplus exists.
3. Start-Up Costs
   Group/Staff - very high because of centralized locations.
   IPA - significantly less as services are delivered from existing offices and facilities.
4. Track Record
   Group/Staff - history of containing costs
   IPA - record is uneven.

Source

1. U.S. Department of Health and Human Services, Public Health Service.
2. Massachusetts Hospital Association.

II. PPOs

Defininition

Preferred Provider Arrangements (PPAs) are those in which physicians, hospitals, and/or other health care providers contract to provide health care on a negotiated fee-for-service basis to set groups of

Continued on next page

Alternate Delivery Systems Buyer's Guide

Continued from previous page

beneficiaries. They can be looked upon as a brokering of services between a defined group of providers and purchasers (employers, insurance carriers, etc.) for the purpose of delivering services at negotiated prices.

A Preferred Provider Organization (PPO) is the organizational structure which develops and/or coordinates the contracts among providers and between providers and purchasers participating in the arrangement. While there is much diversity in PPO organizational structure and function, they nonetheless have certain basic and key elements. Not all PPOs will have all, most or some of these elements. The Greater Detroit Area Health Council[1] succintly defined these elements as:

"- a provider panel which is a defined selected number of providers;
- negotiated rates (often on a discounted basis);
- contractual arrangements between providers and purchasers regarding the provision of service to subscribers;
- a defined group of subscribers/patients;
- retention of consumers' freedom of choice regarding providers (although this freedom may, in effect, be limited due to economic disincentives to use non-PPO providers);
- economic incentives for consumers to utilize PPO providers, and;
- a utilization and/or claims review function."

A PPO benefit is the incremental coverage above and beyond the standard insurance plan which provides the insured with the incentive to use a provider participating in the preferred arrangement. This incremental coverage is only in effect when the preferred provider is used. The insured retains standard coverage for all services not rendered by a preferred provider, therefore maintaining freedom of provider choice at all times.

Background, Growth, and Regulatory Environment

PPOs are a relatively new alternative reimbursement/delivery system. While a couple of PPOs were in existence in 1981, by 1983 there were 60 PPOs nationally, and by calendar year 1984 end, 140.[2,3]

At the present time most states, including Massachusetts, do not have any specific legislation governing the operation of PPOs. However, the outlook is bright for the passage of additional PPO bills. Since California became the first state to authorize the negotiation of fixed fee-for-service contracts with doctors and hospitals in 1982, nine additional states have approved these arrangements in 1984: Florida, Indiana, Louisiana, Minnesota, Michigan, Nebraska, Utah, Virginia, and Wisconsin.[4] While there are also no federal laws specifically governing PPOs, the government has authorized demonstration projects in California and Michigan. In addition, a Presidential Commission has recommended that Medicare adopt a PPO-type program for reimbursing physicians.

Two major reasons can be attributed to the absence of state and federal regulation. First, PPOs are a relatively new concept for health care delivery, and the legislative process has not had time to address it. Second, and perhaps most important, many PPOs have been established as a network or alliance, rather than a formal legal corporation. The absence of one entity responsible for all facets of the program makes it difficult to regulate. Some states are planning to regulate PPOs according to their sponsorship and organizational structure. In Massachusetts, as in many other states, the applicability of present insurance codes, HMO laws and hospital rate setting regulations to PPOs is uncertain. Also of concern are federal anti-trust laws prohibiting price fixing and other anti-competitive activities. In this regard, it should be noted that the Federal Trade Commission rendered an opinion on a PPO under development in New Jersey, indicating that it did not violate anti-trust laws and was in fact pro-competitive.

The Health Insurance Association of America (HIAA) has indicated that the degree of freedom with which insurance carriers may negotiate with providers in forming PPOs varies greatly from state to state. The National Association of Insurance Commissions (HAIC) is in the process of developing model guidelines for state legislation governing PPOs.

While the regulatory environment is largely uncertain at the present time and the prospect of future legislation probable, it can be stated that the Federal Government and many states have implied support of the pro-competitive characteristics of PPOs. Careful consideration should be given to the

governance and structure of the PPO and all legal issues should be explored before an organization elects to participate in a PPO. Unlike an HMO, PPO coverage is *not* an alternative to the traditional insurance plan. Employees do not choose PPO coverage. PPO coverage is added to the standard benefit coverage changing it from a traditional to a non-traditional health insurance plan.

Models/Types

As mentioned previously, there is much diversity in the structure and design of PPOs. Therefore, it is difficult to describe discrete "models." There are, however, discrete variations in PPO design and structure. Those are:

1. Sponsorship, which can be:
   a. provider based—hospital, physician, hospital/physician joint venture, other provider organization/group
   b. payor-based—insurance carriers, non-profit hospital service plans, health care service plans, government, employers, union trust funds
   c. entrepreneurial—third party administrator, insurance broker, other parties independent of both providers and payors
2. Panel Composition
   a. single provider or provider group
   b. network of several providers or provider groups

   Panel composition will affect the degree of provider choice available to employees who want to use their PPO benefit. Since most PPOs rely upon voluntary insured use of preferred providers to achieve savings, the employer must assess the network with regard to the particular employee population.
3. Panel Selection Criteria
   a. open panel—any provider can join at any time
   b. closed panel—providers are selected based on criteria

   Panel selection criteria may affect the degree of control the PPO has over participating providers utilization patterns. Some PPO experts maintain that the closed panel can achieve better savings because it has carefully selected providers based on current utilization patters, and because the number of providers directs more patient volume to fewer practitioners, thereby increasing the participating providers' desire to remain on the panel. Other experts maintain that the open panel concept provides for greater provider choice, and therefore will increase and consequently increase savings to the plan.
4. Insured Incentive Mechanism
   a. swing mechanism—better benefit for use of PPO provider or higher coinsurance/or deductible for use of non-PPO providers
   b. exclusive mechanism—no coverage for non-PPO provider use

   The incentive for the insured to use the PPO will affect savings since savings are directly related to the frequency with which the program is used. The "swing" method provides a better benefit to the insured if he/she uses a preferred provider, and at the same time maximizes freedom of provider choice by allowing the insured to receive services from a non-PPO provider and have these covered under the standard plan. Under the "swing" method, the employer must rely on employee choice to achieve savings.

   The "exclusive" mechanism only provides benefits if the insured uses a preferred provider and, therefore, eliminates freedom of choice outside the network. This mechanism is sometimes referred to as an Exclusive Provider Organization (EPO). The EPO looks very much like an IPA HMO, but differs in that it operates on a fee-for-service rather than a prepaid basis.

Sources

1. Greater Detroit Area Health Council, Inc. Policy Statement on Preferred Provider Organizations (PPOs)
2. Clearing House on Preferred Provider Organizations - 1983 (Institute for International Health Initiative Affiliated with the American Medical Care and Review Association)
3. Clearing House on Preferred Provider Organizations - 1984 (Institute for International Health Initiative Affiliated with the American Medical Care and Review Association) ■

Scenes From The Annual Meeting

Dr. Terrence O'Neill, Legislative Committe chairman, presents his report.

Dr. Asinas, incoming HDMS president, is flanked by Dr. Smith, outgoing president, and Dr. Slachta, president-elect.

Two 50 year members, Wayne C. Barnes and I. Daniel Hosman, were able to attend.

Dr. Smith conducts his last HDMS business meeting with Dr. Walthall, secretary, and Mrs. Nystrom, executive secretary.

Notes And Quotes Of Interest:

Congratulations to *Burritt L. Haag, M.D.*, who received the Pfizer Award from the American Diabetes Association June 15 as outstanding Clinician in diabetes for 1985. Dr. Haag is chief of the Endocrine-Metabolic Service at Baystate Medical Center.

The *Air National Guard* at Barnes Airport in Westfield is looking for qualified physicians to spend a weekend a month and two weeks of field training a year with numerous benefits and even flight pay. Call (413)568-9215 for further information. ■

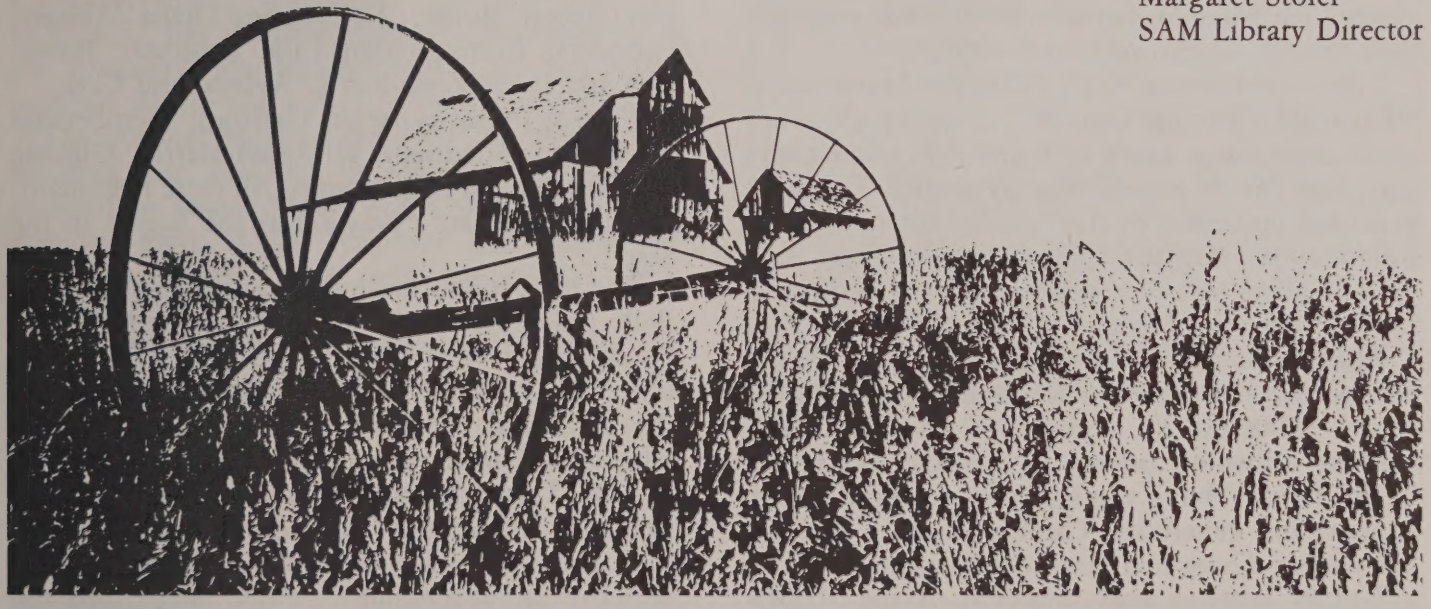
S.A.M. Update

The IBM PC Computer which will serve HDMS and SAM has been installed and through the kindness and dedication of Dr. George Pelletier, and is slowly becoming a very useful tool for both Mrs. Nystrom and myself. With the summer months to practice and the unending assistance of Dr. Pelletier, we will, no doubt, be computer "experts" by September.

As of June 6th, when the Academy received its first electronic mail Inter Library Loan request from the J.B. Thomas Hospital in Peabody, MA., SAM is "online" with Medlink. Kudos to Dr. Pelletier and HDMS for making this all possible.

At the June 7th Western Mass. Health Information Consortium meeting held at the Berkshire Medical Center in Pittsfield, I was elected Chairman for the coming year. Hopefully it will be a fruitful year, not only for WMHIC but for the Academy as well. ■

Margaret Stoler
SAM Library Director



ORIENTAL RUGS
We buy and sell Oriental Rugs
MARKARIAN & MARKARIAN
EST. 1895
472 BRIDGE STREET, SPRINGFIELD
at APREMONT TRIANGLE 737-1227
ANTIQUE and SEMI-ANTIQUE RUGS
AUTHENTIC OIL PAINTINGS
INDIAN and CHINESE RUGS

Hampden District Medical Society Auxiliary

Annual Report 1984-1985

Time, energy and commitment is the keynote of the Hampden District Medical Society Auxiliary. Patience, dedication, support, and loyalty of the board and membership were the ingredients of a successful year.

The Auxiliary continued its Shared Concern series to which the Valley District Dental Women were invited. In October, the first general meeting on "Quality Medical Family Life" with Anita Taylor, co-author of "Couples-The Art of Staying Together" was guest speaker. She offered theories of couple dynamics and with a homework assignment, problem recognition and resolution, leading to enhancing and strengthening of the couple unit. This program appeared to appeal to our younger membership as about sixty Auxilians and Dental women participated. Lorraine Penhos was program co-ordinator for this successful event.

The second in the Shared Concern Series was a "Financial Planning Seminar". Topics such as acquisition of assets, assets for retirement, estate planning and Tax Awareness were presented. This program was requested by the membership as a direct follow up on Margurite Tracy's "More Than Survival." Ellen McGuire was program co-ordinator for this successful event.

Another successful Scholarship Campaign Fund was held in November. The Auxiliary was able to award $3000.00 in scholarships to seven area students pursuing careers in nursing and allied health fields. Thank you again for your continued support and generosity. Carolyn Letteney was the Scholarship Campaign Fund chairperson.

Norma Sears, a past president of the HDMS Auxiliary, opened her home for the Auxiliary's Annual Holiday Tea. Under the capable direction of Carrol-Jean Yorzyk, Carol Trachtenberg and Laura Fernandez, it was a success with new friends making friends, old friends getting reacquainted.

January brought forth the Auxiliary's first evening general meeting. Mrs. Jean Rogers, wife of the A.M.A. president-elect, was our guest. Following the meeting, Auxilians joined their spouses for the Medical society's dinner with area legislators.

The Auxiliary's Comunity Seminar "Families in Crisis" was held in March at Springfield College. Dr. Warren Schumacher was the keynote speaker. Continuing education units were given by the Auxiliary to nurses who participated. Jane Condon and her committee worked hard to ensure the success that it was.

On Doctor's Day, three area physicians, Wayne C. Barnes, M.D., Joseph Hahn, M.D., and I. Daniel Hosman, M.D., were honored for 50 years of service to our community with a donation to our scholarship fund.

Auxiliary committees functioned efficiently within the organization and are the strength and foundation of all the Auxiliary's activities. Among those are: Membership-Ginny Walthall and Elaine Alexander; Treasurers-Kathy Mouchantat, Audrey Botnick and Nan Hough; Secretaries-Betty Lynch and Eileen Burke; Nominating-Diana Abbasy; Hippocrat Correspondant-Julie Pohlman; Invitation and reservations-Kay D'Avanzo and Cary DeCenzo; Publicity-Helen Gallivan; Membership Book-Myra Wiedman; Historian-Martha Giguere and By-laws-Alice Cummings. All these help maintain the Auxiliary's position as the largest in the State.

The Health Education Committee co-chaired by Polly Miller and Susan Burstein has continued its docent program at the Springfield Science Museum. They continue to develop a new program on the brain and nervous system to be used by the schools and other programs currently used with T.A.M. These chairpersons and committee members have represented the Auxiliary with tireless effort. They need more Auxilians or friends to help with the docent programs. Reward their efforts and volunteer—The rewards are many!

Auxilians Joan Guardione, Jean Medrek and Polly Miller are involved on the Steering Committee for the New Health Hall at the Science Museum soon to be a reality.

The Child Passengar Safety Committee has been promoting the BUCKLE UP campaign all year. The bench seat with safety belts and child restraints was on display at the September 1984 Big E, Agawam Police Department and presently at the Holyoke Children's Museum as a "hands-on" exhibit. Many thanks to Audrey Rich and Debbie Calvanese

for a job well done.

Legislative chairperson Carol Trachtenberg worked very hard on project Med Vote. Her efforts contributed to the Mass. Medical Society Auxiliary being recognized nationally by the A.M.A. for encouraging physicians to register and vote.

The Auxiliary has kept active on the State and National Level. Ginny Walthall, president-elect, attended the A.M.A. Auxiliary National Conference. Jane Condon, Joan Guardione and Audrey Rich have served on the State Executive Committee and board. Your Auxiliary has been represented to all functions that it was invited to.

The Auxiliary has contributed $520.00 to A.M.A.-ERF, chaired by Jane Condon, through holiday card sales and a Share Card. Thank you for your continued support to our medical schools.

The Auxiliary assisted the Hampden District Medical Society acting as hostesses and Mrs. Patricia Smith acted as nutritional consultant for their meetings.

Also the Auxiliary is pleased to announce that Carol Nystrom, Executive Secretary of the H.D.M.S., has accepted Honorary Membership in the Auxiliary. She was nominated for her extraordinary service and advice to the Auxiliary.

The Annual Meeting denotes the end of this business year, followed by lunch and a program planned by Diana Abassy and Cynthia Bye. State President-elect Anna Ferguson and Recording Secretary Estelle Ringer will install the 1985-1986 officers.

1984-1985 has been a rewarding season for the Auxiliary and for me, your president. I would like to thank my family, Dr. Lorne Smith, president of the H.D.M.S., the membership and my board for their support, direction and help. ■

Respectfully submitted,
Vicki Kiss (Mrs. William D.)
President
Hampden District Medical
Society Auxiliary

Hampden District Medical Society Auxiliary Officers 1985-86

The Hampden District Medical Society Auxiliary announces the 1985-1986 Officers as duly nominated and elected at the Annual Meeting, May 1, 1985 at the Colony Club. They are as follows:

President:	Mrs. Virginia Walthall
President-Elect:	Mrs. Betty Lynch
Recording Secretary:	Mrs. Debbie Calvanese
Corresponding Secretary:	Mrs. Eileen Burke
Treasurer:	Mrs. Susan Burstein
Scholarship Treasurer:	Mrs. Kathy Mouchantat
Directors:	Mrs. Vicki Kiss
	Mrs. Audrey Botnick
	Mrs. Linda Markarian
Nominating Chairperson:	Mrs. Carolyn Letteney

VNA.
Visiting Nurse Association of Springfield, Inc.
600 Berkshire Ave.
Springfield, MA 01109
781-5070

HOME HEALTH SERVICES
24 hours a day - 7 days a week

NURSING
PHYSICAL THERAPY
HOMEMAKERS
HOME HEALTH AIDES
OCCUPATIONAL THERAPY
SPEECH THERAPY
MEDICAL SOCIAL SERVICES
VOLUNTARY CARE GIVERS

Certified for Medicare-Medicaid/United Way Agency

Serving: Agawam, East Longmeadow, Longmeadow, Ludlow, Hampden, West Springfield, Southwick, Springfield, Westfield and Wilbraham

Auxiliary Scholarship Award Winners

The Hampden District Medical Society Auxiliary Scholarship award winners for 1985 -1986 are:

BEDARD, JANET L.
$500 award, new
233 Homestead Avenue
Holyoke, Mass. 01040
Age 18 Parents are Ernest and Eleanor Bedard
Janet will be a freshman at Bridgeport University, Ct.
B.S. in Nursing

CROSSMAN, ALAENA LYNNE
$500 award, new
47 Breezy Knool Road
East Longmeadow, Mass. 01028
Age 18 Parents are Donald and Ann Crossman
Alaena will be a freshman at Fairfield University, Ct.
B.S. Nursing

LACERTE, MICHELLE MARIE
$500 award, new
245 Pineview Circle
Agawam, Mass. 01001
Age 18 Mother is Marilyn Lacerte
Michelle will be a freshman at Northeastern University, Boston, Mass.
B.A. Physical Therapy

MINICUCCI, MARIE
$500 award, new
14 Linden Avenue
Westfield, Mass. 01085
Age 19 Parents are Angelo and Joan Minicucci
Marie will be a sophomore at Our Lady of the Elms College
B.S. Nursing

PIKE, MELISSA JULIE
$250 award, new
R.F.D. Russell Road
Montgomery, Mass. 01085
Age 21 Parents are Robert and Julie Pike
Melissa will be a senior at Baystate School of Nursing
R.N. Nursing

SMITH, LORI A.
$250 award, new
75 Birnie Avenue
West Springfield, Mass. 01089
Age 20 Parents are Allen and Hazel Smith
Lori will be a sophomore at Our Lady of the Elms College
B.S. in Nursing

TURNBERG, JOAN S.
$500 renew
267 Hampden Road
East Longmeadow, Mass. 01028
Age 18 Parents are Ronald and Mary Turnberg
Joan will be a sophomore at Framingham State College
B.S., Medical Technology

ESTABLISHED IN THE YEAR 1851
Dickinson-Streeter Funeral Service
305 STATE ST., SPRINGFIELD, MASS.
Earle C. Bradley Alfred J. Gay

Welcome New Members

Timothy M. Lopez, M.D.
759 Chestnut St.
Springfield, MA 01107 RESIDENT

BORN:	November 14, 1958
PREMED:	Pomona College 9/76-5/80
MEDICAL:	University of New Mexico 9/80-5/84
INTERNSHIP:	Baystate Medical Center 7/84-present

Brigid K. Glackin, M.D.
780 Chestnut St.
Springfield, MA 01107

BORN:	October 4, 1948
PREMED:	New York University 1966-70
MEDICAL:	SUNY/DOWNSTATE NY 1970-77
INTERNSHIP:	Royal Victorian Hospital 1977-78
RESIDENCY:	Baystate Medical Center 1978-82
FELLOWSHIP:	Montefiore Medical Center, Bronx, NY 1983-84

Patrick F. Caulfield, M.D.
691 College Highway
Southwick, MA 01077

BORN:	October 4, 1944
PREMED:	St. Anselm's College, New Hampshire 1971-74
MEDICAL:	University of New Mexico, Albuquerque 8/74-5/78
INTERNSHIP:	Medical Center Hospital, Burlington, VT 7/78-7/79
RESIDENCY:	Medical Center of Vermont 8/79-7/81
SPECIALTY:	FAMILY PRACTICE

Joseph H. Sklar, M.D.
39 Mulberry St.
Springfield, MA 01105

BORN:	January 18, 1949
PREMED:	U. Pennsylvania 1967-71
MEDICAL:	U. Pennsylvania 9/75-5/79
INTERNSHIP:	Parillano Hospital, Texas 1979-81
RESIDENCY:	Mass. General Hospital 6/81-12/84
FELLOWSHIP:	Brigham & Woman's Hospital 1/85-5/85
SPECIALTY:	ORTHOPEDIC SURGEON

Irene M. Barzilai, M.D.
759 Chestnut St.
Springfield, MA 01107 RESIDENT

BORN:	August 26, 1955
PREMED:	University of Pennsylvania 1973-78
MEDICAL:	Temple University, Philadelphia 1979-83
INTERNSHIP:	Baystate Medical Center 1983-84
RESIDENCY:	Baystate Medical Center/Radiology Department 7/84-present

David T. Lyons, M.D.
759 Chestnut St.
Springfield, MA 01107

BORN:	March 14, 1952
PREMED:	University of Rochester, NY 1970-74
MEDICAL:	University of Vermont College of Medicine 9/74-5/78
INTERNSHIP:	Babies Hospital, Columbia Presbyterian, NY 7/78-6/79
RESIDENCY:	Babies Hospital, NY 7/79-6/81
FELLOWSHIP:	Babies Hospital, NY 7/81-6/83 Cornell University Medical College, NY 7/83-6/84
SPECIALTY:	NEONATOLOGY/PEDIATRICS

Maurice J. Whalen, M.D.
300 Stafford St.
Springfield, MA 01104

BORN:	December 24, 1949
PREMED:	John's Hopkins University 1968-72
MEDICAL:	S.U.N.Y. Upstate Medical College 1972-1976
INTERNSHIP:	Barnes/Washington University, St. Louis 7/76-6/77
RESIDENCY:	Barnes/Internal Medicine 7/77-6/80 Barnes/Opthamology 7/80-6/84
SPECIALTY:	OPTHALMOLOGY

Thomas Gartman, M.D.
444 Montgomery St.
Chicopee, MA 01020

BORN:	October 7, 1953
PREMED:	New York University, NY 9/69-6/73
MEDICAL:	Boston University School of Medicine 1973-77
INTERNSHIP:	Hospital of St. Raphael, New Haven, CT 1977-78
RESIDENCY:	Hospital of St. Raphael 1978-80
FELLOWSHIP:	Hospital of St. Raphael 1980-82
SPECIALTY:	INTERNAL MEDICINE/ ENDOCRINOLOGY

Shwee-Tian Chou, M.D.
91 School St.
Springfield, MA 01105

BORN:	November 19, 1942
PREMED:	Taipei Medical College, Republic of China 1965-68
MEDICAL:	Taipei Medical College 1967-73
INTERNSHIP:	Air Force General Hospital, Taipei Medical College, 1971-7/72
RESIDENCY:	National First Health Screening Hospital 1978-81
SPECIALTY:	GENERAL PRACTICE/ACUPUNCTURE

In Memoriam

LOUIS G. SPELIOS, M.D.

A practicing physician in Springfield for more than 50 years, Dr. Spelios died April 22, 1985 in Mercy Hospital at age 79. He was born in Greece and lived in Springfield for over 65 years. He was a member of the Mercy Hospital Medical Staff since 1934. He is survived by two sons, a daughter, and six grandchildren.

HARRY A. BAKER, M.D.

Dr. Baker, 77, died April 24, 1985 in the VA Hospital, Northampton. He had lived in Holyoke since 1934 and practiced internal medicine and cardiology, being a staff member of Providence Hospital for over 50 years. He leaves his wife, Rose; a son; a daughter, Myra Shayevitz, M.D., one of his practice associates; a sister and four grandchildren.

JAMES MURPHY, M.D.

A resident of Palmer for 60 years, Dr. Murphy, 93 died in Mary Lane Hospital, Ware recently. He specialized in Otolaryngology and was an Army veteran of WWI, after which he established his practice in Palmer. He leaves his wife, Margaret, two sons, a daughter, two sisters and three grandsons.

TENORMIN
TENORETIC TABLETS
MYLANTA LIQUID
Frank Bobbin
Stuart Pharmaceutical

PENSION ASSOCIATES INC.
1234 Main Street
Springfield, Mass. 01103
781-1261

CONSULTATION
AND
ADMINISTRATION
FOR ALL TYPES OF
EMPLOYEE
BENEFIT PLANS
and
EXECUTIVE
COMPENSATION
PLANS

William R. Massida
Robert A. Walker
Richard A. Labine

Dine in
Relaxed Elegance

Always a different and delicious menu to enjoy in pleasant comfort. Serving daily from eleven-thirty AM to midnight.

THE LOG CABIN
Easthampton Road, Route 141
HOLYOKE
536-7700

Look to us for direction.

Shawmut
First Bank

Members FDIC. Equal Housing Lenders.

CHALLENGE

PHYSICAL THERAPY AND REHABILITATION

LOCATION: 62 Westfield St.
West Springfield, MA 01089
(on Rte. 20 in West Springfield Center)

PURPOSE: The provision of quality physical therapy services that assure the physician of a continuation of his high medical standards.

FEATURING:
- **Convenient location**
- **significantly lower fees**
- **extended morning and evening hours**

REFERRAL: Call Challenge at 734-3269 or give the patient a written prescription.

ANNOUNCING THE MERGER OF HIGH PERFORMANCE WITH HIGH FINANCE.

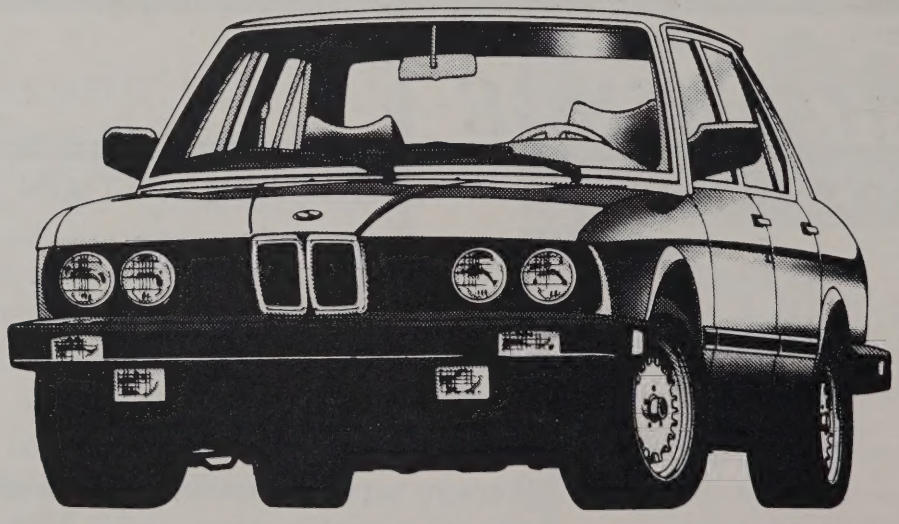
Now that the forces of automotive engineering and financial services have converged, it's easier than it's ever been to finance your Ultimate Driving Machine.

The cause of such good news is the BMW Credit Corporation—a joint financial venture between BMW of North America and the General Electric Credit Corporation.

And through it, we can offer to you "one-stop" financing, competitive rates and the backing of one of the largest diversified financial services corporations in the U.S.

So contact us for details. And announce your own historic merger: you and a BMW.

THE ULTIMATE DRIVING MACHINE.



BALISE

The Best Place to BUY a BMW is also the Best Place to LEASE a BMW !

603 East Columbus Ave., Downtown Springfield • Just Off Route 91 • (413) 785-1311